Revitalizing Touch

Client Information Sheet

Name: ______________________________ Today's Date: ____________________

Address: ____________________________________ Apt #: ______________

City: ______________________ Province: ____________ Postal Code: ____________

Home Ph#: ____________________ Other Phone #: ____________________________

Fax #: ______________________ Email Address: ____________________________

Occupation: __________________ Date of Birth: ____________________________

Have you ever received massage before? If yes, what kind and how often?

Are you here for Relaxation?_____ Therapeutic? ____ Both? ____

What are your immediate areas of concern?

Secondary area of concern?

Have you suffered any accidents, had any surgery? Yes ____ No ____

If yes, when and what part of the body was involved?

Have you been treated by a chiropractor , physiotherapist or any other alternative health practitioner?
Yes ____ No ____

If yes, for what?

By whom?

Are you taking any medication? If so, for what?

Are you pregnant? If yes, how many weeks? _____ Any children? ____

AA BI ZII BIZH (Ojibiwe word)

Health Problems:

Aids/HIV	Allergies
Cancer	Asthma
Diabetes	Skin problems
Digestion Problems	Arthritis
Epilepsy	Liver
Heart Disease	Kidney/Urinary problems
High Blood Pressure	Varicose veins
Low Blood Pressure	

Other: (Do you have any medical conditions not yet mentioned?

Lifestyle:	Smoke?	How much?
	Alcohol?	How much?
	Coffee?	How much?

How much water do you drink in a day?

Do you have three complete meals a day? Yes ____ No ____

If there is any other information that you think we need to be able to give you the best possible massage, please do not hesitate to tell us. All your questions are very much welcomed.

All the above information will be kept strictly confidential.

The above is a true statement of my physical condition to the best of my knowledge.

Signature: ____________________________ Date: ____________________________

"Every Body needs to be Kneaded"